

Extract of 11/4 Presentation of DHHS Center for Disease Control and Prevention
By Jane Orbeton, OPLA, 11/7

1. US DHHS, Four Overarching Goals of Healthy People 2020

- Attaining high-quality, longer lives
- Achieving health equity
- Creating environments that promote good health
- Promoting quality of life and healthy development and behaviors across all life stages

2. Maine DHHS Shared Goals Related to Healthy Maine 2010

- a. Access to quality health care, disease prevention and health promotion
- b. Chronic disease
- c. Environmental health
- d. Reproductive health
- e. Infectious disease and immunization
- f. Injury prevention
- g. Mental health
- h. Occupational health
- i. Physical activity and nutrition
- j. Substance abuse prevention
- k. Identify disparities in outcomes among all populations
- l. Direct resources toward reducing or eliminating inequalities in health outcomes
- m. Levels of prevention activities

3. Maine DHHS Strategies to Improve Health Outcomes

- a. Build community capacity
- b. Build state and local public health capacity
- c. Workforce development
- d. Access to community prevention interventions
- e. Access to health and dental insurance
- f. Reducing barriers to high quality care
- g. Improving quality of health care systems

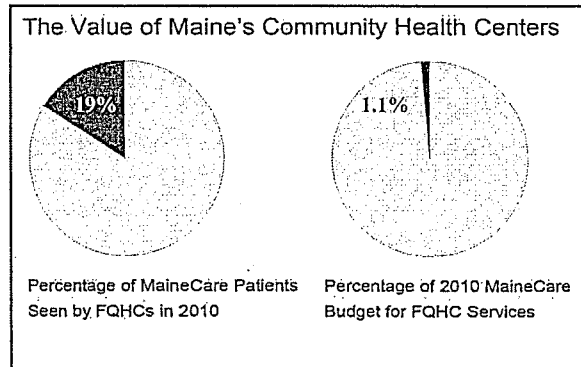
Information from Dr. Thomas Freiden, US DHHS, Center for Disease Control and Prevention	
"Winnable Battles"	"5-Tier Health Impact Pyramid"
Healthcare-associated infections HIV in the US Motor vehicle injuries Nutrition, physical activity and obesity Teen pregnancy Tobacco use	Counseling and education Clinical interventions Long lasting protective interventions Changes in environmental context Changes in socioeconomic factors

- **School-Based Health Care:** 1/3 of Maine's school-based health centers are sponsored by community health centers. By working together, they are able to reach more adolescents with preventive services in school, as well as leverage infrastructure resources such as electronic health records.
- **Child Care:** Whether it is through a day care center in their building or developing a relationship with a local HeadStart or CAP agency, CHCs are increasingly connecting their patients to child care services and voucher programs.

Value

Community health centers serve some of Maine's highest need individuals, yet are able to provide high quality care at a high value.

In 2011, Maine's community health centers provided care to 19% of the Medicaid population, while accounting for only 1.1% of the total state Medicaid expenditures. Health centers have also improved the lives of thousands of Mainers and have saved millions of dollars by reducing higher spending downstream, by avoiding unnecessary hospitalizations and costly emergency room visits. Much of this savings has to do with CHCs' focus on preventive care.



National studies consistently demonstrate that health centers save their respective Medicaid programs three dollars (\$3) for every dollar (\$1) spent on health center services. Utilizing community health centers as a hub of preventive care and referrals to existing community resources creates opportunities to maximize the very limited funds that we do have for prevention. At the same time, CHCs continue to support the public health infrastructure and preventive health programming that has been developed through past investments; CHCs are looking forward to continuing their alignment with Fund for Healthy Maine strategies.

Alignment: Fund for a Healthy Maine

Community Health Centers provide services outlined in the FHM enabling legislation, even while balancing financial challenges that threaten their ability to stay focused on preventive care and health promotion activities. As outlined in Statute §1511(6), the Fund is to be used for purposes including: (A) Smoking prevention, cessation and control activities; (B) Prenatal and young children's care including home visits and support for parents of children from birth to six years of age; (C) Child care for children up to 15 years of age; (D) health care for children and adults; (F) Dental and oral health care to low income persons who lack adequate dental coverage; (G) Substance abuse prevention; and (H) Comprehensive school health and nutrition programs, including school based health centers. All of these services are part of the community health centers' comprehensive primary care approach.

The Fund for a Healthy Maine signals an important commitment to prevention, wellness and reduced downstream cost for Maine communities. As community health centers help to accomplish so many of the Fund's goals--through a focus on community-based prevention activities, a focus on effectiveness and value in care delivery, and continued alignment with FHM funding statute--we strongly encourage this Commission to keep the Fund dedicated to prevention and health promotion activities as it was intended.



Kevin A. Lewis, *CEO*

Testimony before the Commission to Study the Fund for a Healthy Maine

**Kevin Lewis, Chief Executive Officer, Maine Primary Care Association
November 17, 2011**

Senator McCormick, Representative Sanderson and Distinguished Members of the Committee:
The Maine Primary Care Association appreciates this opportunity to present testimony regarding the Fund for a Healthy Maine. Community health centers (CHCs) support their communities through prevention and strive to improve population health while achieving Fund for a Healthy Maine goals.

What makes community health centers (CHCs) different?

CHCs are unique because they bridge public health and health care through comprehensive preventive and primary care services in the following ways:

Community-Based Care

- **Community Board Governance:** 51% of the CHC governing board must be users of the health center
- **Address Community Needs:** Aside from providing core services, CHCs continually reassess what additional services they need to integrate to serve their community, such as substance abuse or child care.
- **Partner with Existing Community Resources:** CHCs work with existing community agencies such as Area Agencies on Aging, Community Action Programs, and others to facilitate continuity of care once a patient leaves the health center.
- **Collaborate with Healthy Maine Partnerships and local public health districts:** CHCs work with local public health entities to offer programs and events to their communities and patients in areas including healthy eating/weight management and tobacco cessation, among others.

Focus on Prevention

Community Health Centers focus on prevention as an integral component of their comprehensive primary care offerings. Given that community health centers serve some of Maine's highest need patients, integrated prevention and 'enabling' services such as transportation and child care are the building blocks on which patient-centered care is based. Such services, in line with the goals of the Fund for Healthy Maine, are provided by CHCs. These include, but are not limited to:

- **Tobacco Cessation:** Counseling and follow up offered by CHC trained staff (Center for Tobacco Independence training) and referral to the statewide tobacco helpline when appropriate.
- **Chronic Disease Self Management:** Community health centers offer "Living Well" classes and other chronic disease self management tools to community members.
- **Healthy Weight Management:** Community health centers develop localized solutions to weight management, including: Construction of a walking track for community use; community fitness center, (at a community health center); and nutrition counseling and healthy cooking classes.
- **Substance Abuse Prevention:** On-site treatment and counseling services available at many CHCs, including strategies to address the increasing opiate abuse is seen in many of Maine's rural communities. Also, use of the Prescription Drug Monitoring Program continues to be well-used by CHC providers.
- **Oral Health Care:** As a core CHC service, cleanings, fluoride varnish and other preventive services are offered to community members on a sliding scale. By working in collaboration with programs such as From the First Tooth, they also extend their reach into the primary care office.
- **Immunizations:** Community health centers are key distributors for influenza vaccine to many of Maine's rural communities, helping to limit the spread of vaccine preventable diseases.

PORTLAND ADMINISTRATION

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**Planned Parenthood's Support for the Fund for a Healthy Maine, to the Commission to Study Allocations of the Fund for a Healthy Maine
November 17, 2011**

Senator McCormick, Representative Sanderson, Members of the Commission to Study Allocations on the Fund for a Healthy Maine, I am Megan Hannan, Director of Public Affairs for Planned Parenthood of Northern New England, Maine. You have heard a thorough summary of family planning services and funding in Maine. I am here to offer you an opportunity to make our state dollars go farther, and to serve more women and prevent more unintended pregnancies.

Those of you on the Appropriations and Financial Affairs and Health and Human Services Committees have heard me talk about this issue before, but for many members of this Commission this will be new.

The US Government has put a high value on family planning since it was funded through Title X, in 1970. When Medicaid started paying for family planning services specifically, DHHS and Congress decided to match states at an enhanced rate, \$9 Federal to \$1 state, so that states would commit to this coverage. States were also allowed and encouraged to file for a family planning waiver in order to cover more eligible women. The Affordable Care Act continues the tradition of valuing family planning, and goes a step further by easing administrative burden of a waiver process, and now allows states to amend their Medicaid plan to include family planning – and only family planning – for women up to the same percent as they cover pregnant women, which in Maine is 200% of Federal poverty level.

What the state plan amendment will do is allow women to visit health centers for family planning advice and supplies. This includes community health centers and primary care facilities that take MaineCare patients. This is not akin to adding more people to a program that many in this building would like to cut. This is adding specific services to women from 100 to 200% of poverty. A single woman making under \$22,000 a year is at 200% of poverty; in a family of four, it's under \$45,000.

As was mentioned earlier, women spend decades of their lives trying not to get pregnant. In this economy, more couples are waiting to have children. This is a tool we should have for women to take personal responsibility for their lives and futures, so that they can stay in school, work to move up, and to appropriately space the children she plans to have.

This saves the state money two ways: by lowering MaineCare costs for unintended pregnancies, high risk pregnancies, and, once implemented, could affect the direct appropriations we are now getting. Because we work on a sliding scale we can probably never completely unfund family planning if we want to continue our low teen pregnancy rate, but this would go a long way to give more access to women who want and need this service.

Thank you very much for your time.

Megan D. Hannan

megan.hannan@ppnne.org | 207.210.3409 | 207.687.3289

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Family Planning Works for Maine – Unintended Pregnancy

- In Maine in 2006, 50% of all pregnancies were unintended. Yet, we have the second lowest unintended pregnancy rate (37 per 1,000) in the US.
- Unfortunately, we also have the highest increase in that rate, at 21% from 2002 – 2006.
- Unintended pregnancies have many consequences: lower use of prenatal care; continued substance abuse, including tobacco and alcohol; higher abortion rates; and mistreated, abandoned, or abused children.
- *Access to effective, affordable birth control is the answer to this problem.*

Family Planning Works for Maine – MaineCare Savings

- In Maine in 2006, 14,200 children were born.
- Of those children, just under 45% were on MaineCare; of those, over 65% were unintended.
- Total MaineCare spending on birth in 2006 was almost \$56 million; cost for unintended births was just over \$31 million.
- MaineCare match for family planning services is \$9 - \$1. Nine Federal dollars match our one state dollar.
- We can take advantage of a state plan amendment to cover women for family planning services *only*, up to 200% of poverty, the same as we now cover pregnant women.
- The amount the Governor's proposed budget diverts from family planning services to MaineCare in the Fund for a Healthy Maine, about \$425,000, is sufficient to cover every eligible woman in Maine. We should use that money to draw down \$9 rather than \$2.
- Lowering the rate of unintended pregnancies in low income women saves the state money and allows women to choose the timing of their pregnancy.
- Fully implemented, it will save the state almost \$2 million.
- *Access to effective, affordable birth control is the answer to this problem.*
- *Affordable birth control is available with the family planning state plan amendment.*

Data provided by the Guttmacher Institute, Jan and May, 2011. Cited data are from 2006.

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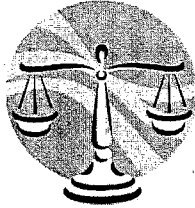
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Testimony on funding for MaineCare and Drugs for the Elderly Program
through the Fund for a Healthy Maine

November 17, 2011

My name is Ana Hicks. I work for Maine Equal Justice Partners. MEJP is a legal services organization which works to find solutions to poverty and improve the lives of people with low income in Maine.

I'm here to talk a little about MaineCare and the Drugs for the Elderly program and why funding for these programs is included in the Fund for Healthy Maine.

It was decided when the Fund was first established that we needed a combination of strategies to create a healthy state. Access to health care coverage through MaineCare and the Drugs for the Elderly and Disabled program was a fundamental part of the prescription for a healthier Maine.

The MaineCare program plays an important role in our health care system, providing critical health care to low-income children and their parents, seniors, people with disabilities and other adults. Thanks in large part to the MaineCare program, our state has one of the lowest uninsured rates in the country.

Today Maine is ranked as the 8th healthiest state in the nation by the United Health Foundation – factored into this ranking is where the state falls in covering the uninsured. We have made great strides in this area relative to other states. In 1999 at the time that the fund was established, Maine was ranked 26th for its rate of health coverage and today it is ranked 6th.

The care that MaineCare beneficiaries receive, including preventive care and services to manage a chronic disease, can help make them healthier and more productive, while also reducing their need for health services over the long term.

I wanted to share a few stories that I think highlight the role that MaineCare plays in helping with prevention and helping people to manage their chronic disease as well as work and be successful in their daily lives.

Heather is in her mid-20's. She does all that she can on her own to stay healthy, but as a child, she was diagnosed with Type 1 diabetes. Prior to receiving MaineCare, she was without health insurance and was having serious health problems as a result of being unable to control her diabetes. With the help of MaineCare she has been able to stabilize her health and is now working full time as a nurse's aide with health insurance provided by her employer.

Sean works two jobs to support his two young children. Because Sean is on MaineCare, his doctor was able to detect a fatal heart condition and provide him surgery to save his life. Since that time Sean receives the on-going prescription coverage and regular check-ups that he needs to stay alive, healthy and able to work and care for his children.

The Drugs for the Elderly and Disabled Program has been an extremely successful program that has helped to ensure that low income seniors and people with disabilities living on fixed incomes do not have to choose between food, heat and medicine.

The program has changed since the Fund went into effect. Originally the program was a solely state funded program that helped people to directly purchase prescription drugs. In 2005, Congress passed the Medicare Part D Prescription Drug Program. At the time Maine had a strong state prescription assistance program, known as Drug for the Elderly. While Medicare Part D was a huge benefit to seniors and people with disabilities with no prior coverage, in Maine seniors would have lost ground without continued funding for Maine's existing drug program. The funding for the program that is provided through the Fund for Healthy Maine was needed to ensure that people were held harmless by the changes at the federal level. We are now

wisely using these funds to help these individuals to participate in the Medicare Savings Program which was a more efficient and cost-effective method to protect coverage for low income Maine seniors and people with disabilities.

By helping people to cover the cost of their prescription drugs, the DEL program is helping people with disabilities and seniors to manage chronic diseases and their health. Without access to needed prescription drugs, many of these enrollees would likely end up in the hospital, long term care or other institutional care. Clearly this is a wise investment for the state to make in the health and well-being of seniors and people with disabilities.

Thank you for the opportunity to speak.

Oral Health Services Impacted by Cuts to the Fund for a Healthy Maine

Dental Clinic Subsidies-- \$677,726 in SFY11 reduced to \$350,000 in SFY12

The reduction in the Oral Health allocation means that of the over 50,000 people who receive services at community clinics with sliding scale fees, some may lose the opportunity to see a dentist or hygienist at a price they can afford. Forty-four percent of all patients served at community clinics qualify for a sliding fee scale subsidized by the Fund for a Healthy Maine. Of these patients, 74% were adult MaineCare members who do not receive dental benefits but value their oral health. Because of the cut, only 6 organizations providing dental services at 12 sites, compared to 13 providing services at 19 locations, receive funds and the available amounts were reduced. Community clinics have raised their fees, and may serve fewer working families.

Maine's high rate of emergency department (ED) use due to dental issues may rise even higher.

Dental pain is the leading cause of ED use among the uninsured and Maine Care enrollees aged 15-45 and more patients may go to the ED for costly care that doesn't solve their dental problem. The average ED cost for dental care is 10 times that for the same procedures in a clinic setting—and the ED only treats the symptoms, not the cause leading to more trips to the ED in the future.

School Oral Health Program--\$250,000 in SFY11, maintained in SFY12

Further cuts to the FHM will impact 30,000 school children in 236 schools who receive oral health education or services through the state-funded School Oral Health Program. Under current funding 236 schools participate in the School Oral Health Program under a formula that determines eligibility based on factors such as the availability of community water fluoridation and the percent of students eligible for the free lunch program. When a school qualifies, *all* students in that school may receive services regardless of income level. The Oral Health Program reviewed school eligibility and performance to keep the number of schools and funding within available funds.

There are already 9,772 children in schools that qualify for the School Oral Health Program, but are not served due to lack of funds. These are only the schools that have contacted the Oral Health Program and are on a waiting list; more schools are eligible. Current levels of funding do not meet the need. In the biennial budget of 2009, \$250,000 designated for Oral Health in the General Fund was supplanted by money from the Fund for a Healthy Maine. If the oral health funds are cut from the FHM, the state oral health program will lose these funds as well, and has no other source to support school-based programs.

Loan Repayment and Dental School Loans--\$251,735 in SFY11 reduced to \$237,740 in SFY12

Opportunities for dentists to establish small businesses in Maine will be reduced. Dental practices are small businesses. By helping a dentist repay educational loans, dental loan repayment programs are an opportunity for economic development and small business investment. Dental school is expensive, and many new dentists finish their training with debt exceeding \$250,000. Loans help manage that debt, and carry a service repayment provision, offering an incentive for Mainers to return home to practice.

A new dental practice can bring over a half a million dollars annually in economic activity to a rural community. A new dental office can add as many as 13 new jobs to the local economy. Compared to other small businesses, such as a car dealership, dental practices are high value-added businesses. (JADA, VOL 135, March 2004) Maine's ratio of dentists to patients is among the worst in the country—and 41% of our dentists are over 55 years old. Other businesses may not want to locate in an area where their employees cannot receive services. Also, medical costs are higher in areas where access to dental care services is limited.

Submitted by the Maine Dental Access Coalition.



To: Members of the Commission to Study Allocations of the Fund for a Healthy Maine
Fr: Hilary Schneider, State Director of Government Relations and Advocacy, American Cancer Society
Date: November 17, 2011
Re: Public Comments at November 4th Meeting

As promised, I am providing you with written comments that summarize the public comments that I made at your November 4th Commission meeting. My name is Hilary Schneider and I serve as the State Director of Government Relations and Advocacy for the American Cancer Society. As you may know, the American Cancer Society is the nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service. While we are a national organization, we provide many services at the state and local levels. These include a toll-free number for cancer information and resources (1.800.227.2345), rides to treatment, discounted lodging, and many other support services for cancer patients and their families.

It is estimated that this year 8,820 Mainers will hear the words "you have cancer." It is also estimated that 3,180 Mainers will die from cancer this year. Approximately 1 in 2 men and 1 in 3 women will be diagnosed with cancer at some point in their lifetime. As was included in the Maine CDC presentation to the Commission, cancer is the number one killer in Maine – in most states across the nation, it is heart disease.

Much of the suffering and death from cancer could be prevented by more systematic efforts to reduce tobacco use, improve diet and physical activity, reduce obesity, and expand the use of established cancer screening tests.

The American Cancer Society estimates that nationally in 2011, 171,600 cancer deaths will be caused by tobacco use alone. Tobacco use increases the risk of at least 15 types of cancer, and 30 percent of all cancer deaths, including 87 percent of lung cancer deaths, can be attributed to using tobacco. In addition, Maine's smoking attributable mortality rate is higher than the national average.

Approximately one-third of the 572,210 cancer deaths expected to occur in the United States in 2011 are attributable to poor nutrition, physical inactivity, overweight and obesity.

Regular use of established cancer screening tests can prevent cancer through identification and removal or treatment of pre-malignant abnormalities. They can also improve survival and decrease mortality by detecting cancer at an early stage when the disease is more treatable.

We applaud the Commission's hard work and efforts to tackle the task of reviewing the Fund for a Healthy Maine allocations to determine if they are consistent with the state's current public health priorities. We also applaud the Commission's recognition that while there is substantial



evidence supporting the types of programs that have proven effective at reducing preventable disease risk factors, there is not one single “silver bullet” solution. Individual health behaviors are influenced and supported by a complex set of factors that not only relate to personal attitudes and beliefs, but also relate to the built environment, culture, race, education, income, and many other factors. Social, economic and legislative factors profoundly influence individual health behaviors. Examples of this include:

- The price and availability of healthy foods and tobacco products
- Incentives and opportunities for regular physical activity in schools and communities
- Content of advertising aimed at children
- Availability of insurance coverage for screening tests and tobacco addiction

Examples of evidence-based interventions that effectively decrease preventable risk factors for cancer include:

- Increases in tobacco excise taxes, restrictions on smoking in public places, prevention and cessation programs, and effective anti-tobacco media campaigns
- Limit availability, advertising, and marketing of foods and beverages of low nutritional value, particularly in schools; increase and enforce physical education and health education requirements in grades K-12; and effective media campaigns to increase awareness of healthy lifestyles and educate the public about the connection between nutrition, physical inactivity, overweight/obesity with chronic disease
- Effective sun safety community programs in schools and recreation/tourism, which include education about sun safety and providing physical environments (e.g., shaded areas) that support sun safety
- Efforts to improve access to and utilization of cancer screening, e.g., mammograms, pap tests, colorectal screening

Thank you for the opportunity to provide public comments as your Commission undertakes its work. I would be happy to answer any questions you may have about these comments or provide you with additional information.



Return on Investments in Public Health: A Summary of Groundbreaking Research Studies

Background

The Patient Protection and Affordable Care Act (PL 111-148) included the creation of the Prevention and Public Health Fund, a 10-year, \$15 billion commitment to support programs, medical screenings, and research related to public health and prevention.

Mandatory funding for this groundbreaking initiative includes \$5 billion between Fiscal Year (FY) 2010 and FY2014, with an additional \$10 billion between FY2015 and FY2019. The fund is designed to be ongoing, so funding will continue beyond FY2019. Since its creation, \$1.25 billion has already been appropriated for FY2010 (\$500 million)¹ and FY2011 (\$750 million).²

This funding will be distributed to programs aligned with the National Prevention and Health Promotion Strategy, our country's first-ever comprehensive action plan for improving the health of all Americans. The Strategy outlines four overarching areas on which the nation's prevention efforts should focus: building healthy and safe communities; expanding quality preventive services in both clinical and community settings; empowering people to make healthy choices; and eliminating health disparities.³

This national commitment to and investment in preventing disease before it occurs is in line with evidence from a variety of recent reports and studies indicating that strategic investments in proven, community-based prevention programs could result in significant U.S. health care cost savings and overall economic cost savings. This brief summarizes the findings and recommendations from four major studies released between 2008 and 2011.

Key Findings and Recommendations

- A July 2011 study published in the journal *Health Affairs* found that increased spending by local public health departments can save lives currently lost to preventable illnesses.⁴ Researchers Glen P. Mays and Sharla A. Smith mapped spending by local public health agencies from 1993-2005 with preventable mortality rates in each agency's respective jurisdiction. The report found:

FAST FACTS

Health Care Spending in the United States

- Chronic conditions such as heart disease, cancer, stroke and diabetes are responsible for seven in 10 deaths among Americans each year, and account for nearly 75 percent of the nation's health spending.⁸ More than 40 percent of the population has more than one chronic health condition.⁹
- Preventing disease and injury is the most cost-effective, common-sense way to improve health in the United States. Too often, however, the health care system focuses more on treating disease and injury after they happen. America spends more than \$2 trillion annually on health care—more than any other nation.
- The United States spends hundreds of billions of dollars annually to treat preventable illnesses and diseases. For instance, health care expenditures tied just to smoking total \$96 billion.¹⁰ Costs associated with conditions caused by obesity are also astronomical, including nearly \$17 billion for diabetes and more than \$43 billion for hypertension.¹¹
- For every dollar spent on health care in the United States today, only about four cents goes towards public health and prevention.¹²



- On average, local public health spending rose from \$34.68 per capita in 1993 to \$40.84 per capita in 2005 – an increase of more than 17 percent.
- For each 10 percent increase in local public health spending, there were significant decreases in infant deaths (6.9 percent drop), deaths from cardiovascular disease (3.2 percent drop), deaths from diabetes (1.4 percent drop), and deaths from cancer (1.1 percent drop).
- The 3.2 percent decrease in cardiovascular disease mortality cited above required local health agencies to spend, on average, an additional \$312,274 each year. In contrast, achieving the same reduction in deaths from cardiovascular disease by focusing on treatment and other traditional health *care* approaches would require an additional 27 primary care physicians in the average metropolitan community. To put this comparison in perspective, the median salary for a single primary care physician was \$202,392 in 2010 – as a result, 27 primary care physicians would cost nearly \$5.5 million, or more than 27 times the public health investment.⁵
- **Recommendation: Sustain public health investments to improve community health outcomes and reduce medical costs in the long-term. Additional public health spending would be expected to generate substantial health improvements over time.**
- A 2011 Urban Institute study concluded that it is in the nation's best interest from both a health and economic standpoint to maintain funding for evidence-based, public health programs that save lives and bring down costs. Authors Timothy Waidmann, Barbara Ormond and Randall Bovbjerg examined the financial costs and health ramifications of ignoring disease prevention. The study found:
 - The American health care system currently spends \$238 billion per year in “excess costs” – defined as the difference between the cost of care for people with preventable chronic disease and those without – to treat people with type 2 diabetes, hypertension, heart disease and stroke. More than half of those costs are financed through Medicare and Medicaid. Left unchecked, those excess costs would rise to \$466.5 billion per year by 2030, with nearly \$300 billion financed by Medicare and Medicaid.
 - By 2030, if current trends continue for chronic diseases among all persons ages 45-64, one-third will have hypertension, more than one-quarter will have diabetes, more than 11 percent will have heart disease, and nearly two percent will have strokes. Similar prevalence rate increases can be expected for persons ages 65 or

POLICY PERSPECTIVE

Community Transformation Grants

- Community Transformation Grants¹³ (CTG's) were announced in May 2011 by the Department of Health and Human Services as the newest component of the Prevention and Public Health Fund.
- CTG's are aimed at helping communities implement projects proven to reduce chronic diseases.
- An initial \$103 million in grant funding was awarded to 61 states and communities in September 2011¹⁴ to support the following priority areas: tobacco-free living; active living and healthy eating; and quality clinical and other preventive services, with a specific focus on controlling high blood pressure and high cholesterol.
- Of the 61 grantees – which are located in 36 states and serve a combined 120 million residents – 35 will implement proven health and wellness interventions, while 26 will work to lay a foundation for sustainable community prevention efforts.



older – in particular, more than half of persons in this age group will have diabetes and/or hypertension. These increases will affect not just public sector budgets but private sector costs and competitiveness.

- Slowing the rate of growth of these chronic diseases will save lives and money. For instance, cutting the rate of chronic disease growth by even five percent would save Medicare and Medicaid \$5.5 billion per year by 2030; cutting the rate of chronic disease growth by 25 percent would save \$26.2 billion per year; and cutting the rate of chronic disease growth by 50 percent would save \$48.9 billion per year.
- Investments in primary prevention programs will not only help slow the chronic disease rate, but have also been shown to lower private insurance costs and improve economic productivity while reducing worker absenteeism. In fact, savings achieved through prevention programs can significantly and quickly outweigh initial, upfront investments.
- **Recommendation: Preserve and sustain primary prevention programs for chronic diseases in order to save lives and reduce costs.**
- A May 2011 study published in *Health Affairs* showed that a **combination of three strategies – expanding health insurance coverage, delivering better preventive and chronic care, and focusing on “protection” (a specific prevention strategy defined as enabling healthier behavior and safer environments) – is more effective at saving lives and money than implementing any one of these strategies alone.** A team of researchers led by Bobby Milstein tested all three strategies in a dynamic simulation model of the United States health care system. The report⁶ found:
 - While all three strategies save lives and improve economic conditions, insurance coverage and medical care for chronic conditions lead to an increase in health costs.
 - Of the three, only the preventive steps taken through protection efforts slow the growth in the prevalence of disease and injury, alleviating the demand on limited primary care capacity.
 - Adding preventive protection elements to an expansion of insurance coverage and medical care could save 90 percent more lives and reduce costs by 30 percent within 10 years; those figures rise to 142 percent and 62 percent, respectively, within 25 years.
 - **Recommendation: Ensure that efforts to protect health and encourage healthy behavior— are a core element of disease prevention.**

PREVENTION AND PUBLIC HEALTH INITIATIVES

Program Success Stories

- The U.S. Diabetes Prevention Program screens adults at high risk for developing diabetes. Early results have shown that such screening can reduce the incidence rate of diabetes by more than 50 percent. These interventions have also resulted in weight loss, increased physical activity and improved eating habits.
- Smoking cessation programs that have included referrals to a community-based “quitline” and expanded clinician counseling have shown to be more successful than traditional, less intensive cessation strategies.
- Early diagnosis and treatment of HIV-positive persons with oral antiretroviral medicines reduced HIV transmission by 96 percent. The conclusions were so clear that researchers ended the study early.



- In 2008, Trust for America's Health and the Robert Wood Johnson Foundation released a report showing that an investment of \$10 per person annually in proven, community-based public health programs could save the United States more than \$16 billion within five years—a \$5.60 return for every \$1 invested. The report – based on a model developed by researchers at the Urban Institute and a review of studies conducted by the New York Academy of Medicine – focused on community-based disease prevention programs that do not require medical care. Additional findings⁷ included:

- The \$16 billion in savings would be spread through Medicare (\$5 billion), Medicaid (\$1.9 billion), and private payers (\$9 billion).
- Every state in the nation would be on the receiving end of potential return on investment within that five-year period, ranging from a rate of 3.7 to 1 at the low end to 9.9 to 1 on the high end.
- **Recommendation:** As a significant cost-savings measure, policymakers at all levels of government should invest in disease prevention programs that are separate and distinct from those that require traditional medical care.

Endnotes

- 1 <http://www.hhs.gov/news/press/2010pres/06/20100618g.html>
- 2 <http://www.hhs.gov/news/press/2011pres/02/20110209b.html>
- 3 <http://www.healthcare.gov/center/councils/nphpphc/strategy/report.pdf>
- 4 <http://content.healthaffairs.org/content/early/2011/07/19/hlthaff.2011.0196.full.pdf+html>
- 5 <http://www.mgma.com/physcomp/>
- 6 <http://content.healthaffairs.org/content/early/2011/07/19/hlthaff.2011.0196.full.pdf+html>
- 7 <http://healthyamericans.org/reports/prevention08/Prevention08.pdf>
- 8 <http://www.healthreform.gov/newsroom/preventioncouncil.html>
- 9 <http://healthreformgps.org/resources/chronic-disease-management/>
- 10 <http://www.tobaccofreekids.org/research/factsheets/pdf/0072.pdf>
- 11 <http://chronicdiseaseimpact.org>
- 12 <http://healthyamericans.org/assets/files/TFAH%202010Top10PrioritiesDiseasePrevention.pdf>
- 13 <http://www.hhs.gov/news/press/2011pres/05/20110513b.html>
- 14 <http://www.hhs.gov/news/press/2011pres/09/20110927a.html>
- 15 <http://www.hhs.gov/recovery/programs/cppw/granteesbystate.html>

PREVENTION AND PUBLIC HEALTH INITIATIVES

Community Policy and Program Success Stories¹⁶

Active living and school nutrition in Alabama

In Jefferson County, prevention funds were used to develop walkable greenways and other open spaces, and promote exercise as medicine through employer-sponsored flexible spending accounts. The Jefferson County Public Schools also initiated a program to contract with local growers to add local produce as part of school lunches – 56 county schools are now participating in the program.

Tobacco reduction in Georgia

The Dekalb County Board of Health unanimously passed a resolution endorsing a smoke-free air ordinance, while Oglethorpe University signed a formal agreement to make all of its campuses tobacco-free. Prevention funds will be used to enhance smoking cessation programs and to support pricing strategies designed to decrease tobacco usage.

Healthy foods in Kentucky

In Louisville, the Healthy Hometown Restaurant Initiative has led to the calculation and printing of calories information of menu items at 18 restaurants that serve more than 435,000 people. Additionally, Jefferson County Public Schools used grant funding to create a Community Action plan that will reduce sodium and sugar in school meals, and increase the amount of food brought into schools by local farmers and through school gardens.

Massachusetts' Perfect Storm

Massachusetts had a 'perfect storm' of interventions that reaped them noticeable benefits among their Medicaid population in recent years. Mass. interventions are explained in the **MassHealth Example** below. Most of the things Mass. did, Maine has done incrementally over time. Maine would not be able to show the dramatic results that Mass. did when they implemented several things all at once. Compared to the Mass. items, our MaineCare recipients have good benefits for tobacco cessation and can access the HelpLine for counseling. Maine still has a copay for MaineCare recipients and requires prior authorization for pharmacotherapy. Maine conducts ongoing, effective media campaigns that motivate smokers to quit and to direct smokers to the HelpLine. Maine provides free nicotine patches when a client has no insurance benefit. Mass. had a \$1.00 tax increase during this time, which is a complicated process and one not under the control of public health program.

MassHealth Example:

In April 2006, Massachusetts passed An Act Providing Access to Affordable, Quality, Accountable Health Care, requiring all individuals in Massachusetts to have health insurance and mandating coverage within the Medicaid program for tobacco cessation treatment: behavioral counseling and coverage of all FDA-approved pharmacotherapy for tobacco treatment.

- Between July 1, 2006 and December 31, 2008, a total of 70,140 unique Massachusetts Medicaid (MassHealth) clients used the new tobacco treatment benefit, accounting for 37% of the total MassHealth smoking population.^{iv}
- The rate of smoking among MassHealth members decreased by 26%, from 38.3% to 28.3%.^v
 - ✓ ☐ Prior to July 2006, there was no significant change in smoking prevalence among the MassHealth population. Beginning in July 2006, smoking prevalence among the population began to drop at an annual rate of 15.2%.

The MassHealth benefit was significantly improved by removing barriers for access to tobacco treatment by Medicaid recipients and promoting the benefit to the target population through a number of mediums.

- The MassHealth Benefit provides subscribers with two 90-day courses per year of FDA approved medications for smoking cessation, including OTC medications (i.e. patch, lozenge and inhalers) and up to 16 individual or group counseling sessions. Prior authorization is not required for prescribing pharmacotherapy, with the exception of the nasal inhaler and spray. Copayments for medication are \$1.00-\$3.00, and clients cannot be denied their medication if they are unable to pay their copays.
- Smoking cessation was promoted broadly to the full Massachusetts population in a number of ways between 2006 and 2008. The Massachusetts Tobacco Control Program ran a general media campaign, pharmaceutical companies advertised products for cessation, the helpline began providing free nicotine patches to callers and on July 1, 2008, Massachusetts raised their cigarette tax by a \$1.00.

- Use of the tobacco cessation pharmacotherapy benefit by MassHealth recipients was associated with a 46% annual decrease in hospitalizations for acute myocardial infarction and a 49% annual decrease in hospitalizations for coronary atherosclerosis.vii
 - Hospitalizations for heart attacks and other coronary heart disease are expensive.
 - Reducing these hospitalizations will reduce health care expenditures.
- Medical savings from reduced hospitalizations for heart attacks and coronary atherosclerosis in the first two years was \$12.7 million. The cost of tobacco treatment medications in the first two years was \$11.5 million. Therefore, the net savings was \$1.2 million, or \$1.11 return for every dollar spent.viii

Maine's MaineCare data:

Despite overall reductions in smoking prevalence throughout Maine, MaineCare clients continue to smoke at a rate more than twice that of the general adult population (41.4% vs. 17.2%).Source: BRFSS 2009.

Tobacco related costs make up more than 10% of the Medicaid budget, accounting for more than \$216 million in preventable costs. Tobacco use in general accounts for \$602 million in healthcare costs to the State every year. Source: Campaign for Tobacco Free Kids 2009

Helping people quit smoking saves lives and prevents chronic illness while saving the state millions of dollars. By helping Medicaid recipients quit their addiction to tobacco we can reduce the burden on individuals and businesses, making Maine a healthier, more prosperous state.

It takes a smoker an average of 5-7 attempts before they can successfully quit their addiction to tobacco.

Note: Citations did not copy.

Family Planning and the Fund for a Healthy Maine

Submitted to the Commission to Study Allocations of the Fund for a Healthy Maine
By the Family Planning Association of Maine
November 17, 2011

MAINE'S FAMILY PLANNING SYSTEM

Maine's family planning system, administered by the Family Planning Association of Maine, is made up of a variety of community-based, nonprofit organizations providing reproductive health services at 46 health centers across the state. Together, we provided health care to more than 27,000 women, men and teens in the most recent fiscal year. 82% of our patients had household incomes below 250% of the Federal Poverty Level, qualifying them for free or reduced-cost services.

Family planning services include basic health screenings, gynecological services, contraceptive care, cancer screening, testing and treatment for sexually transmitted infections, pregnancy testing and a variety of other basic health care.

THE NEED FOR FAMILY PLANNING SERVICES

The typical American woman who wants two children will spend about 5 years pregnant, postpartum or attempting to become pregnant, and three decades attempting to avoid pregnancy.ⁱ

Publicly-funded family planning services are targeted to women ages 13 to 44, with household incomes below 250%, who are sexually active are not pregnant or actively trying to become pregnant. A recent study estimates that, in 2008, there were 76,800 Maine women who met this description.ⁱⁱ Maine's family planning system served approximately 35% of them, compared with 27% served by such systems nationally.

Studies show that about half of all American pregnancies are unintended, and those statistics hold up for women in Maine. The rate of unintended pregnancy is particularly high for women with low incomes – poor women in the United States are five times as likely to have an unintended pregnancy as more affluent women, and that disparity has been growing in recent years.ⁱⁱⁱ

Births resulting from unintended pregnancies are much more likely to be supported by public programs than those that result from intended pregnancies: In 2006, 66% of Maine births resulting from unintended pregnancies were covered by MaineCare, compared with 32% of births resulting from intended pregnancies. Births resulting from unintended pregnancies accounted for \$31 million in MaineCare costs in 2006, including \$12 million in state funds.^{iv}

MAINE'S INVESTMENT IN AVOIDING UNINTENDED PREGNANCY

Maine has a long history of supporting family planning service. The state law creating Maine's family planning system was enacted in 1972, and state funding soon followed. Since that time, all state funding has been directed to the Family Planning Association of Maine, which then contracts with a variety of providers to ensure statewide, community-based services.

Because the Family Planning Association has the sole state contract for statewide family planning services, it is easy to identify the sources of state funding dedicated to this system. In FY12, family planning services are budgeted to receive:

Fund for a Healthy Maine:	\$401,430
Community Family Planning:	\$225,322
Maternal/Child Block Grant Match:	\$306,843
Purchased Social Service:	\$205,155
TOTAL:	\$1,138,750

In addition to these state budget appropriations, The FPA receives funding from the Department of Health and Human Services through the Federal Social Services Block Grant in the amount of \$410,274. Although this funding is not reviewed and appropriated by the legislature, it is part of the FPA's contract with the State of Maine, and we consider it in the system's total "state funding" of \$1,549,024 in FY12.

Maine's family planning system is also supported by the federal family planning program, known as the Title X program after Title X of the Public Health Service Act, which created the program in 1970. Maine receives \$2,015,434 in federal funding through Title X each year. The Family Planning Association is the statewide grantee for Title X funding, and this funding is allocated statewide in the same manner as state funding. It should be noted that Title X funding has been targeted for elimination in the current House budget proposal; the second year the House of Representatives has proposed such elimination.

Family planning providers also accept MaineCare and private insurance, and some of our patients pay a small fee according to our sliding fee scale.

THE IMPACT OF FAMILY PLANNING SERVICES IN MAINE

Unintended pregnancy presents clear health, social and economic consequences for women and their families. When women have the ability to space their births, it results in better health for women, for babies, and for families. More broadly, women's ability to rely on contraception enables them to invest in higher education, to be full participants in the workforce, and to support their families.

In 2008, contraceptive services provided at Maine family planning health centers helped women avoid 5,600 unintended pregnancies, which would likely have resulted in 2,500 births and 2,300 abortions.^v

In the absence of these services, the number of unintended pregnancies in Maine would be 63% higher, and the number of abortions would be 92% higher.^{vi}

In 2006, contraceptive services provided at Maine family planning health centers helped women younger than age 20 avoid 2,000 unintended pregnancies.^{vii} In the absence of these services, the number of teen pregnancies in Maine would be 103% higher.^v

Nationally, every public dollar spent to provide family planning services saves almost \$4 in Medicaid costs over the following year.^{viii}

ⁱ Boonstra HD, Gold RB, Richards CL, Finer LB. Abortion in women's lives. Guttmacher Institute; 2006

ⁱⁱ Frost JJ, Henshaw SK and Sonfield A, *Contraceptive Needs and Services, National and State Data, 2008 Update*, New York: Guttmacher Institute, 2010.

ⁱⁱⁱ Finer LB, Zolna MR. Unintended pregnancy in the United States: incidence and disparities, 2006. *Contraception* 2011. doi:10.1016/j.contraception.2011.07.013

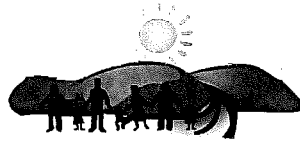
^{iv} Sonfield A et al., *The public costs of births resulting from unintended pregnancies: national and state-level estimates, Perspectives on Sexual and Reproductive Health*, 2011, 43(2):94-102.

^v Frost JJ, Henshaw SK and Sonfield A, *Contraceptive Needs and Services, National and State Data, 2008 Update*, New York: Guttmacher Institute, 2010.

^{vi} Cohen SA, *The numbers tell the story: the reach and impact of Title X, Guttmacher Policy Review*, 2011, 14(2):20-23.

^{vii} Guttmacher Institute Data Center, Number of unintended pregnancies averted to clients aged <20 by Title X-funded family planning centers, 2006, <<http://www.guttmacher.org/datacenter/>>, accessed Feb. 14, 2011.

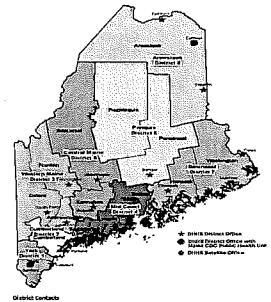
^{viii} Frost JJ, Henshaw SK, Sonfield A. Contraceptive needs and services, national and state data, 2008 update. Guttmacher Institute; 2010.



Maine Network of Healthy Communities

%Choose to Be Healthy~ 15 Hospital Drive ~ York, ME 03909

The Fund for a Healthy Maine & Maine's Public Health Infrastructure



November 17, 2011

Senators, Members of the House of Representatives, and Community Members of the Commission to Study Allocations of the Fund for a Health Maine:

I am Joanne Joy, representing the Maine Network of Healthy Communities. The Network, created in 2002, is the statewide association representing comprehensive community health coalitions including those funded as Healthy Maine Partnerships (HMPs). The tobacco settlement dollars primarily fund key staff members who then engage diverse partners from health care, behavioral health, worksites, schools, social service providers, and employers of all sorts who are contributing their time and resources to make the healthier choices, the easier choices. HMP efforts focus primarily on enhancing policies and environments through these partnerships.

Maine's current Public Health Infrastructure was established in legislation in 2008, and the Maine Tribes were added in 2010. The planning for the current structure began several years prior, as advocates and public health partners came together to consider ways to streamline the existing somewhat erratic system of Grants, Programs, and Initiatives funded through Maine CDC. Forty volunteers from across healthcare, community based organizations, local and state government, and the Maine Legislature collectively reviewed models of effective public health systems from across this and other countries. There was strong support to build on the successes of the Healthy Maine Partnerships, so much work was done to enhance the local level coalitions to all achieve goals as effective organizations, and to increase each coalition's capacity to perform appropriate aspects of the 10 Essential Public Health Services, aligned with the public health accreditation for the state of Maine. Thirty-one School Systems across the state are also part of the Healthy Maine Partnership system, implementing Coordinated School Health Programming. **The local Healthy Maine Partnership coalitions form the local level of the public health infrastructure.** I have no doubt that healthy changes have happened in your towns as a result of these partnerships.

The creation of the Public Health Districts has addressed significant challenges. District Public Health changes all happened within existing resources

- 1) The number of grants issued from Maine CDC for a variety of public health programs has been reduced significantly. The expansion of responsibilities and funding of the HMPs addressed some of those issues, and the creation of 9 Public Health Districts promises to streamline public health efforts and grant processes.
- 2) District Coordinating Councils have been established and are already addressing district-wide issues. Membership here is also volunteer, and efforts are based on local needs and assessments.
- 3) Communication with key public health stakeholders has been enhanced through identified and established channels within the districts.
- 4) Nine existing Maine CDC positions were relocated to the Public Health Districts. These positions, District Liaisons, work within a public health unit where several other MCDC programs are co-located. Communication and support among those programs has been greatly enhanced. These District Liaisons also staff the District Coordinating Councils.

The Statewide Coordinating Council for Public Health is a representative statewide body of public health stakeholders convened for collaborative public health planning and coordination. The Statewide Coordinating Council for Public Health

- Participates as appropriate to help ensure the state public health system is ready and maintained for

accreditation;

- Assists the Maine Center for Disease Control and Prevention in planning for the essential public health services and resources to be provided in each district and across the State in the most efficient, effective and evidence-based manner possible

This advisory body has 22 voting members defined in the legislation. There are also two other levels of participation; Key Stakeholders invited by the Director of the Maine CDC, which represent statewide partners such as the Maine Medical Association, the Lung Association, UNE as Maine's accredited school of public health; as well as self selected Interested Parties. Four subcommittees are currently 10 providing leadership for the Community Transformation Grant; 2) working to align various Needs Assessments and Health Planning processes, 3) determining possible next SCC steps to address issues of the State Public Health System Assessment, and 4) providing insight and guidance for appropriate ways to address health disparities in public health efforts across the state. Need I say again, that these individuals volunteer their time and expertise to Maine.

Enhancements for Local Health Officers were also added to the infrastructure. Maine has had a system of Local Health Officers in every municipality in Maine since the early 1900s. The roles and expectations and training were reviewed, revised and enhanced and acknowledged as key to the health of Maine people.

Maine CDC restructured and created the Office of Local Public Health, established to provide oversight for this system

Should Maine continue to use the Fund for Healthy Maine for the public health infrastructure?

From my perspective, yes, and here are snapshots of why:

Clearly, Maine's status as 9th Healthiest State up from 17th is attributable to multiple factors, including the HMPs, the Districts, and the collaborative efforts among all these partners. Maine's public health infrastructure components and efforts have also brought additional resources to Maine

- It is clear that this new public health infrastructure in our Public Health Districts as well as Maine's focus on community and statewide collaborative solutions to reducing health risks and chronic disease were key factors in the newly awarded Community Transformation Grant of \$1,318,300.00 per year for 5 years.
- Every Healthy Maine Partnership has received additional resources through awards from national, state and local grant makers and foundations. Currently, for instance, 25% of my HMP budget is from other sources. The many Drug Free Communities Grants is a great example of longer term support for Maine work that we could not fund otherwise. Few of those grants would have been available to my organization without the FHM.
- Every funded school with a School Health Coordinator has received additional funds within their school system to create healthier environments – and healthier, more active students who are eating healthier foods have higher achievement and lower rates of unacceptable behaviors.
- Collaborations, integrations, relationships among local HMPs, across Public Health Districts, and at the State Coordinating Council have already lead to more effective and efficient efforts in needs assessments, program design, grant applications, and much more.
- The Maine CDC communications are more systematic, and engage more public health partners, all of which allows Maine people to be informed, make choices for themselves and their families, and for Maine to continue to make progress towards being a healthier state.

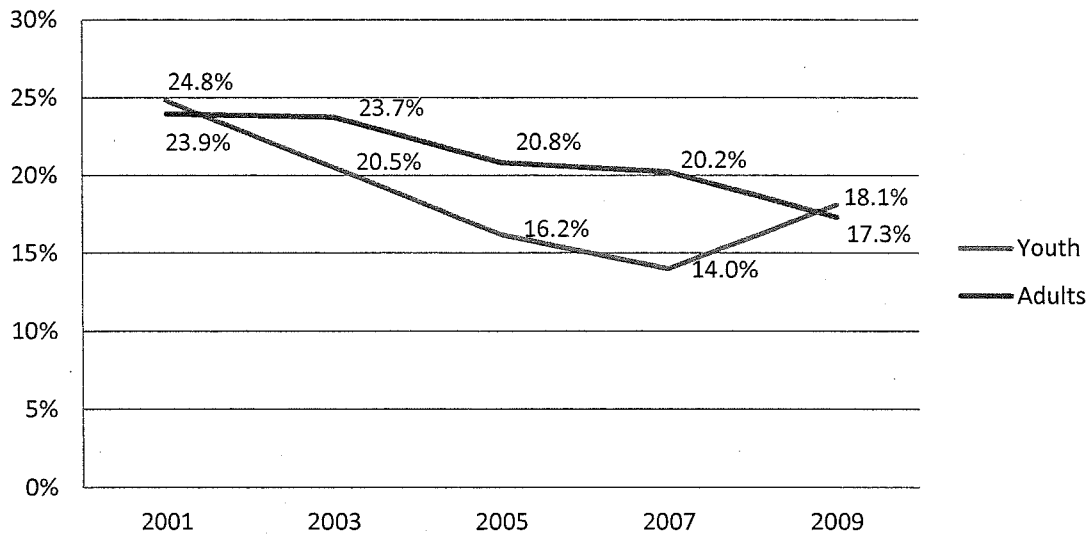
This statewide ability to collaboratively focus on prevention will, right now, help individuals with chronic disease to improve their health status, and, over time, reduce the burden of chronic disease for individuals, families, employers, and the government.

Thank you for your time.

Joanne Joy, Policy Chair, Maine Network of Healthy Communities
Healthy Communities of the Capital Area
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Tobacco Prevention & Control Information

Maine Tobacco Use Rates – Adults & Youth¹



Maine Tobacco Helpline

- Maine's telephone based tobacco Helpline has served over 75,000 customers in 10 years reaching an average of 3% of smokers annually. This reach rate is one of highest rates in the country.
- Of individuals who called the Helpline, approximately 30% were tobacco free seven months after their use of the service, which is considered a good percentage.
- Services are provided at no charge to those who have no applicable insurance. Services include telephone counseling, medication vouchers, quit materials sent by mail, and a web based coaching system for smokers.
- The program reaches out to physicians to encourage them to make referrals. The "fax referral" system prompts a proactive call from the Helpline to the patient (If the patient agrees to the call). 150 practices are visited per year to assist with the implementation of the "fax referral" system and use of best-practices for the identification and treatment of tobacco use.

Maine Tobacco Helpline Registered Callers Fiscal Years 2007-2011					
	2007	2008	2009	2010	2011
MaineCare	1,928 (19.8%)	1,764 (20.7%)	1,700 (21.8%)	1,598 (21.9%)	1,941 (25.5%)
Non-MaineCare	7853 (80.2%)	6,751 (79.3%)	6,116 (78.2%)	5,692 (78.1%)	5682 (74.5%)
TOTAL	9,781	8,515	7,816	7,290	7,623

Media & Communications

- The effectiveness of media and communications is measured in two ways.
 - The first is when individuals call the Helpline, they are asked how they heard about the service. This is in part due to a majority of the media and communications materials containing Helpline information and being designed in a way to motivate utilizing the Helpline for tobacco treatment. Generally, call volume to the Helpline increases during and immediately after a campaign airs. In 2010, respondents answered the following:

¹ Adult rates from Behavioral Risk Factor Surveillance System & Youth rates from Youth Risk Behavioral System

- Employer – 3%
- Other – 12%
- Family / Friend – 19%
- **Media – 27%**
- Health Provider – 39%
- The second is through an evaluation tool called a communications check, which is a telephone survey that aims to assess individuals' recollection of recently sponsored media communications. One recent communications checks indicated that 4-of-10 Maine residents could provide "un-aided²" recall from at least one of the key messages for tobacco control and prevention.
- These funds support a variety of educational interventions and social marketing efforts including:
 - Messages about the addictive and health dangers of tobacco
 - Educational materials for distribution to schools, healthcare providers, and members of the public on quitting tobacco and discouraging initiation of tobacco use
 - Research driven and tested messages to counter Tobacco Industry advertising and influence
 - Educational materials creating awareness that secondhand smoke exposure is deadly
 - Materials that assist population groups who are disproportionately affected by tobacco use
 - Messages and materials to raise awareness about the availability and effectiveness of the HelpLine
- The Statewide Tobacco counter-marketing campaign includes television, radio, print, internet messaging and collateral materials to support the four goal areas of the Partnership For A Tobacco Free Maine (Prevention, Cessation, Exposure, and work with Priority Populations). A typical TV media schedule is purchased at an average of 300 weekly GRPs³ within Maine's three media markets: Bangor; Portland; and Presque Isle. Typical campaign costs for a 6-week media schedule (including radio, TV and internet) is \$300,000. U.S. CDC recommends that: a campaign run for at least 6 months to affect awareness; run at least 12-18 months to have an impact on attitudes; and 18-24 months to influence behavior.

MaineCare

- While the overall tobacco use rate among Mainers has significantly decreased in the last decade, the rate among those on MaineCare has remained relatively stable. Whereas the current smoking rate is 18.2%⁴ for the general population, approximately 43% of the MaineCare population are current smokers.
- Recent efforts to address this problem have included a partnership with the Office of MaineCare Services to increase MaineCare providers' access to the "fax referral" system to the Maine Tobacco HelpLine. This service prompts a proactive call from a tobacco treatment specialist, as compared to the individual needing to place the first call themselves. American Recovery and Reinvestment Act funding, a 24 month grant from U.S. CDC that will end in February of 2012, permitted the HelpLine to expand utilization of this service and the HelpLine has since seen an increase in the percentage of individuals calling the HelpLine who are MaineCare recipients (as seen in the above table).
- The Center for Tobacco Independence, in which the Maine Tobacco HelpLine is housed, also provides training to primary care providers on incorporating best-practices for the identification and treatment of tobacco in their routine practices.

² "un-aided" means they were not prompted with reminders of specific campaigns

³ GRP is the measure of the average number of times an individual within the target demographic is exposed to the message within one week

⁴ 2010 BRFSS

Department of the Attorney General
FHM – Attorney General
Account 014-26A-0947-01

The FHM – Attorney General program funds one full-time Assistant Attorney General position to: (1) defend Maine's entitlement to full payments under the tobacco Master Settlement Agreement ("MSA") against challenges by participating tobacco manufacturers; (2) enforce the provisions of the MSA, including public health restrictions such as the ban on youth targeting; and (3) enforce Maine's statute requiring escrow payments from non-participating manufacturers, Maine's directory statute, Maine's retail licensing laws, and Maine's reduced ignition propensity statute. The position is critical to Maine's meeting the diligent enforcement requirement of the MSA, which the participating manufacturers have challenged and are expected to continue to challenge in their ongoing effort to substantially reduce the amount of their payments to the State.

Recent funding history is reflected below.

Line Category	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
Personal Services	115,029	121,290	87,738	95,424
All Other	21,102	22,553	24,102	24,263
TOTAL	136,131	143,843	111,840	119,687

Up until the current fiscal year, Personal Services funding was provided to cover the salary and benefits of 1.5 attorney positions. The half-time position was eliminated in PL 2011, c. 380, Part RRR. All Other expenditures are incurred primarily in the areas of contractual services, travel, staff training, information technology and for the state's indirect cost allocation assessment.

Dirigo Health
FHM – Dirigo Health
Account 014-95D-Z070-01

The FHM – Dirigo Health program began receiving Fund for a Healthy Maine allocations in fiscal year 2008-09. Funds were to be used for the purposes of the Dirigo Health Program which was established to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis and to monitor and improve the quality of health care in this State. Funds currently allocated to the FHM – Dirigo Health program are used solely to support access to the DirigoChoice product for members with nominal assets and household incomes under 300% of the federal poverty limit. Current biennium allocations will support approximately 385 members.

Recent program history is reflected below.

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
All Other	4,683,443	4,441,791	1,161,647	1,161,647
TOTAL	4,683,443	4,441,791	1,161,647	1,161,647

The Governor's proposed 2012-2013 biennial budget included an initiative to end Fund for a Healthy Maine allocations for the FHM – Dirigo Health program. The final biennial budget bill enacted by the Legislature, Public Law 2011, c. 380 included allocations for this program, although at a reduced level.

Department of Education
FHM – School Nurse Consultant
Account 014-05A-0949-10

The purpose of the FHM - School Nurse Consultant program is to provide ongoing consultation, policy development and technical assistance to the nearly 400 school nurses across the State. School nurses in Maine provide health services to students in order to assist them to be ready to learn. With changes in Federal regulations that require students to be educated in the least restrictive environment, many medically fragile students are now attending school. There are increasing numbers of students in school with diabetes, asthma and other chronic health conditions. School nurses are responsible for the health services provided to all students, are involved with environmental health and public health issues of the school, and work with school, parents and community health providers to improve the health of students.

Specifically the school nurse consultant: serves as a liaison and resource expert in school nursing and school health care program areas; monitors, interprets, synthesizes and disseminates relevant information; fosters and promotes staff development for school nurses; and gathers and analyzes data relevant to the school health care program and monitors standards to promote school nursing excellence and optimal health of school children.

The FHM allocation provided funding for the salary and benefits of one Education Specialist III position and related operating costs including staff travel, information technology charges and the state's indirect cost allocation assessment.

Recent funding history is reflected below.

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
Positions - Legislative Count	1.000	1.000	0.000	0.000
Personal Services	92,871	90,353	0	0
All Other	6,503	6,525	0	0
TOTAL	99,374	96,878	0	0

The Governor's proposed 2012-2013 biennial budget included an initiative to end Fund for a Healthy Maine allocations for the FHM – School Nurse Consultant program. This funding reduction was enacted in PL 2011, c. 380; however, the Department of Education was able to identify funding available from the American Recovery and Reinvestment Act of 2009 to create a limited-period position to provide these services for the 2012-2013 biennium. The department is currently exploring federal funding opportunities to continue the position beyond the 2012-2013 biennium.

Department of Education
FHM – School Breakfast Program
Account 014-05A-Z068-01

The FHM – School Breakfast Program provides funds to reimburse local school units that provide breakfasts to those students eligible for the reduced-price breakfast benefit for the cost of the breakfast. PL 2007, chapter 539, Part IIII enacted provisions that require public schools that serve breakfast to provide breakfast to students who are eligible for free and reduced-price meals at no cost to the student. The State is required to provide funding to the schools for the difference between the federal reimbursement for a free breakfast and the federal reimbursement for a reduced-price breakfast for each student eligible for a reduced-price breakfast and receiving breakfast. This same law provided Fund for a Healthy Maine allocations, beginning in fiscal year 2008-09, for this purpose.

Recent funding history is reflected below.

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
All Other	168,610	162,474	213,720	213,720
TOTAL	168,610	162,474	213,720	213,720

The Department of Education reimburses school administrative units on a monthly basis. Approximately 165 school units receive reimbursement annually. The department estimates that approximately 701,000 breakfasts are subsidized annually. Fund for a Healthy Maine resources provided in fiscal years 2009-10 and 2010-11 were not sufficient to cover all required costs. For FY 10, additional expenditures of \$35,990 were paid from available Other Special Revenue Funds resources. For FY 2010-11, a General Fund appropriation of \$50,000 was provided to cover the additional costs of which \$39,016 was expended to cover the required program costs. Due to the historical cost trend, effective with fiscal year 2011-12, it was determined that additional allocations were required to meet funding requirements; these allocations were provided in Public Law 2011, chapter 380.

Finance Authority of Maine
FHM – Health Education Centers
Account 014-94F-0950-02

The goal of the FHM – Health Education Centers program is to attract and retain health care personnel in underserved areas of the state and to provide services to underserved cultural groups through educational system incentives. To meet this goal, the Finance Authority of Maine contracts with the University of New England to: provide continuing education courses to promote professional development for rural health professionals; provide clinical placements for health professions students in rural and underserved areas; and expose students in rural areas to health professions through career awareness programs and other educational experiences.

Recent funding history is reflected below.

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
All Other	112,040	106,260	100,353	100,353
TOTAL	112,040	106,260	100,353	100,353

The Governor's proposed 2012-2013 budget proposed to eliminate funding for this program. However, the budget as enacted by the Legislature as Public Law 2011, c. 380 did continue funding for fiscal years 2011-12 and 2012-13 at levels slightly less than what was provided for fiscal year 2010-11.

Finance Authority of Maine
FHM – Dental Education
Account 014-94F-0951-01

The FHM – Dental Education program, the goal of which is to increase the number of dentists practicing in Maine in underserved areas or for underserved populations, is administered by the Finance Authority of Maine. There are two components of the program: The Maine Dental Education Loan Program provides forgivable loans to Maine residents pursuing postgraduate dental education, the goal of which is to increase the number of dentists practicing in Maine in underserved areas or for underserved populations; the Maine Dental Education Loan Repayment Program provides loan repayment assistance for dentists practicing general dentistry in eligible dental care facilities in underserved areas of the state of Maine.

Any Maine resident who is pursuing a career as a dentist and intends to practice primary dental care in an eligible dental care facility in an underserved area in Maine is eligible to apply for a loan under the Maine Dental Education Loan Program. In addition, an applicant must be Maine resident, for purposes other than education, for a minimum of two years prior to matriculation into dental school and must be admitted to a program of dentistry at an accredited institution of dental education, leading to a D.M.D. or D.D.S degree. Loans of up to \$20,000 per year may be awarded, with a maximum aggregate amount of \$80,000. Disbursement of loan funds is made directly to the dental school.

Certain loan program recipients may be granted loan forgiveness. Upon compliance with all necessary procedures, loan recipients practicing in underserved areas will be forgiven 25 percent of their original indebtedness on an annual basis. Loans, plus any accrued interest, must be repaid if a loan recipient is not eligible for forgiveness. If the loan recipient returns to Maine but does not enter an eligible underserved practice, the loan will have to be repaid at an annual rate of interest applicable to Stafford loans at the time of the recipient's original note. The recipient may receive a reduction of ½ percent or 1 percent, dependent on the type of practice they maintain. If the loan recipient does not return to Maine to practice, the loan will have to be repaid with interest at 1.5 percent above the Stafford Loan rate over a ten-year period.

Any dentist licensed to practice in Maine who is employed in or intends to establish a qualified practice, has qualifying outstanding dental education loans, and is not under agreement for loan repayment from a program funded by the National Health Service Corps, is eligible to apply for the Maine Dental Education Loan Repayment Program. The dentist does not have to establish prior Maine residency. Up to \$20,000 per year of loan repayment may be awarded with a maximum aggregate amount of \$80,000. Funds are disbursed directly to the dentist for payment toward outstanding dental education loans. Evidence of payment of outstanding education loans must be provided to receive subsequent disbursements.

Recent funding history is reflected below:

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
All Other	265,428	251,735	237,740	237,740
TOTAL	265,428	251,735	237,740	237,740

	FY10 Actual	FY11 Actual	FY12 Projected	FY13 Projected
Loans Awarded	7	10	8	8
Loan Repayments Awarded	5	2	3	3

Since program's inception, 38 awards, 24 loans and 14 loan repayments have been funded.

Beginning in fiscal year 2000-01 and ending in fiscal year 2007-08, FAME was required annually to award up to three loans or loan repayment agreements annually up to an aggregate of twelve. Beginning in FY 2008-09, FAME is required to award up to three loans or loan repayment agreements annually, and may award additional loans or loan repayment agreements annually as funds permit.

Finance Authority of Maine
FHM – Quality Child Care
Account 014-94F-0952-03

The goal of the FHM – Quality Child Care program was to increase the skills of people working in childcare by providing educational grants for related education. Scholarships were awarded to eligible Maine residents enrolled in postsecondary courses related to early childhood education or child development. Funds for these scholarships were provided by FAME to participating Maine institutions to award to eligible students on an annual basis. FAME was authorized set aside up to 10 percent of available funding as a reserve to help non-degree students and for students attending out-of-state schools. Scholarships amounts were up to \$500 per course within an eligible program of study, for a maximum of two courses per semester and up to a maximum of \$2,000 per student per year. To be eligible for the program, a student needed to be a Maine resident, a United States Citizen or eligible non-citizen, a graduate of an approved secondary school or have successfully completed a general education development examination or its equivalent, must have been accepted for enrollment in an eligible program of study, and must have demonstrated the required financial need.

Recent funding history is reflected below:

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
All Other	160,358	152,084	0	0
TOTAL	160,358	152,084	0	0

	FY10 Actual	FY11 Actual	FY12 Projected	FY13 Projected
Grants Awarded	276	176	-0-	-0-

The 2012-2013 biennial budget proposed by the Governor and enacted by the Legislature as Public Law 2011, chapter 380, eliminated Fund for a Healthy Maine allocations for this program effective with fiscal year 2011-12.

Judicial Department
FHM – Judicial Department
Account 014-40A-0963-01

The Judicial Branch has the authority to establish alcohol and drug treatment programs in the Superior and District Courts in accordance with the Maine Revised Statutes, Title 4, section 421. Allocations to the FHM – Judicial Department program were used to fund the salary of a Coordinator of Diversion and Rehabilitation Programs to assist the Judicial Branch to establish, staff, coordinate, operate and evaluate diversion and rehabilitation programs throughout the courts. Specifically the Coordinator works with all adult drug courts, serves as the liaison with parties involved in drug court cases; problem solve with the courts; and writes grants to obtain additional resources and administers the grants received.

Recent funding history is reflected below.

Line Category	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
	Actual Expenditures	Actual Expenditures	Allocations	Allocations
Positions - Legislative Count	1,000	1,000	0.000	0.000
Personal Services	113,913	107,294	0	0
All Other	722	829	0	0
TOTAL	114,635	108,123	0	0

Personal Services allocations provided for the salary and fringe benefits of the Coordinator position. All Other allocations represent the state's indirect cost allocation assessment.

The Governor's proposed 2012-2013 biennial budget included an initiative to end Fund for a Healthy Maine allocations for the FHM – Judicial Department program. This funding reduction was enacted in PL 2011, c. 380; however, the Judicial Department was able to identify alternative sources of funding to continue the Coordinator position.

Department of Public Safety
FHM – Fire Marshal
Account 014-16A-0964-01

Allocations for the FHM – Fire Marshal program were provided to support staff for the purpose of conducting fire safety inspections of child care facilities seeking new or renewed licenses. Personal Services allocations supported the salary and fringe benefits 3 Public Safety Inspector II positions and a portion of the cost of an Office Assistant II position. There were approximately 3,736 fire safety inspections conducted for the Department of Health and Human Services during SFY2011.

Recent funding history is reflected below:

Line Category	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
Positions - Legislative Count	3.000	3.000	0.000	0.000
Personal Services	237,637	242,439	0	0
All Other	13,227	8,645	0	0
Supplemental AO Allocation	1,140,780			
TOTAL	1,391,644	251,084	0	0

Allocations for All Other generally support staff travel and information technology expenses and the state's indirect cost allocation assessment. In FY 2009-10, a one-time FHM allocation of \$1,140,780 was also provided to the program to pay an accrued balance due to the Fire Marshal's Office related to mandatory inspections of Department of Health and Human Services facilities that provide services to children.

The Governor's proposed 2012-2013 biennial budget included an initiative to end Fund for a Healthy Maine allocations for the FHM – Fire Marshal program. The final 2012-2013 biennial budget instead provided General Fund appropriations to the State Fire Marshal to fund this program.

Fund for a Health Maine
Expenditure/Allocation History
FY 2009-10 through FY 2012-13

Department/Program/Line Category	Account Number	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
Attorney General					
FHM - Attorney General	01426A094701	1,500	1,500	1,000	1,000
Positions - Legislative Count					
Personal Services		115,029	121,290	87,738	95,424
All Other		21,102	22,553	24,102	24,263
TOTAL		136,131	143,843	111,840	119,687
Dirigo Health Agency					
FHM - Dirigo Health	01495DZ07001	0,000	0,000	0,000	0,000
Positions - Legislative Count					
Personal Services		0	0	0	0
All Other		4,683,443	4,441,791	1,161,647	1,161,647
TOTAL		4,683,443	4,441,791	1,161,647	1,161,647
Education					
FHM - School Nurse Consultant	01405A094910	1,000	1,000	0,000	0,000
Positions - Legislative Count					
Personal Services		92,871	90,353	0	0
All Other		6,503	6,525	0	0
TOTAL		99,374	96,878	0	0
FHM - School Breakfast	01405AZ06801	0,000	0,000	0,000	0,000
Positions - Legislative Count					
Personal Services		0	0	0	0
All Other		168,610	162,474	213,720	213,720
TOTAL		168,610	162,474	213,720	213,720
Department of Education - Total					
Positions - Legislative Count					
Personal Services		1,000	1,000	0,000	0,000
All Other		92,871	90,353	0	0
TOTAL		175,113	168,999	213,720	213,720
TOTAL		267,984	259,352	213,720	213,720
Finance Authority of Maine					
FHM - Health Education Centers	01494F095002	0,000	0,000	0,000	0,000
Positions - Legislative Count					
Personal Services		0	0	0	0
All Other		112,040	106,260	100,353	100,353
TOTAL		112,040	106,260	100,353	100,353

Department/Program/Line Category	Account Number	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
FHM - Dental Education	01494F095101				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		265,428	251,735	237,740	237,740
TOTAL		265,428	251,735	237,740	237,740
FHM - Quality Child Care	01494F095203				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		160,358	152,084	0	
TOTAL		160,358	152,084	0	0
Finance Authority of Maine - Total					
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		537,826	510,079	338,093	338,093
TOTAL		537,826	510,079	338,093	338,093
Health and Human Services	01414G094801				
FHM - Substance Abuse					
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		6,351,468	4,919,385	1,848,306	1,848,306
TOTAL		6,351,468	4,919,385	1,848,306	1,848,306
FHM - OSA Medicaid Match	01414G094802				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		0	0	1,257,666	1,257,666
TOTAL		0	0	1,257,666	1,257,666
FHM - Oral Health	01410A095301				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		927,453	925,047	600,000	600,000
TOTAL		927,453	925,047	600,000	600,000
FHM - Tobacco Prevention, Control and Treatment	01410A095302				
Positions - Legislative Count		7.000	7.000	7.000	7.000
Personal Services		443,322	538,391	580,050	599,379
All Other		6,569,657	4,412,244	5,822,030	5,822,114
TOTAL		7,012,979	4,950,635	6,402,080	6,421,493
FHM - Home Visitation	01410A095306				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		5,064,554	5,091,128	2,653,383	2,653,383
TOTAL		5,064,554	5,091,128	2,653,383	2,653,383

Department/Program/Line Category	Account Number	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
FHM - Community/School Grants & SW Coord.	01410A095307				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		209,376	225,881	241,119	252,062
All Other		8,280,369	7,650,577	7,536,860	7,536,860
TOTAL		8,489,745	7,876,458	7,777,979	7,788,922
FHM - Public Health Infrastructure	01410A095308				
Positions - Legislative Count		0.000	1.000	1.000	1.000
Personal Services		0	87,800	108,488	111,001
All Other		1,365,572	1,332,637	1,258,314	1,258,314
TOTAL		1,365,572	1,420,437	1,366,802	1,369,315
FHM - O/ASI Central	01410A095401				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		87	0	0	0
TOTAL		87	0	0	0
FHM - Bureau of Medical Services	01410A095501				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		6,714	0	0	0
All Other		1,859	6	0	0
TOTAL		8,573	6	0	0
FHM - Family Planning	01410A095601				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		448,183	425,061	401,430	401,430
TOTAL		448,183	425,061	401,430	401,430
FHM - Service Center	01410A095701				
Positions - Legislative Count		10.000	5.000	0.000	0.000
Personal Services		724,932	297,137	0	0
All Other		20,103	10,430	0	0
TOTAL		745,035	307,567	0	0
FHM - Donated Dental	01410A095801				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		40,654	36,823	36,463	36,463
TOTAL		40,654	36,823	36,463	36,463
FHM - Head Start	01410A095901				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		1,057,256	1,440,941	1,354,580	1,354,580
TOTAL		1,057,256	1,440,941	1,354,580	1,354,580

Department/Program/Line Category	Account Number	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
FHM - Medical Care	01410A096001				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		6,001,113	5,588,774	7,876,677	7,906,432
TOTAL		6,001,113	5,588,774	7,876,677	7,906,432
FHM - Purchased Social Services	01410A096101				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		3,780,006	4,015,056	3,942,236	3,942,236
TOTAL		3,780,006	4,015,056	3,942,236	3,942,236
FHM - Bone Marrow Screening	01410A096201				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		40,806	131,575	0	0
TOTAL		40,806	131,575	0	0
FHM - Drugs for the Elderly & Disabled	01410AZ01501				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		12,839,107	12,352,334	11,934,230	11,934,230
TOTAL		12,839,107	12,352,334	11,934,230	11,934,230
FHM - Immunization	01410AZ04801				
Positions - Legislative Count		0.000	0.000	0.000	0.000
Personal Services		0	0	0	0
All Other		1,090,710	1,085,499	1,078,884	1,078,884
TOTAL		1,090,710	1,085,499	1,078,884	1,078,884
Department of Health and Human Services - Total					
Positions - Legislative Count		17,000	13,000	8,000	8,000
Personal Services		1,384,344	1,149,209	929,657	962,442
All Other		53,878,957	49,417,517	47,601,059	47,630,898
TOTAL		55,263,301	50,566,726	48,530,716	48,593,340
Judicial Department					
FHM - Judicial Department	01440A096301				
Positions - Legislative Count		1,000	1,000	0.000	0.000
Personal Services		113,913	107,294	0	0
All Other		722	829	0	0
TOTAL		114,635	108,123	0	0
Public Safety					
FHM - Fire Marshal	01416A096401				
Positions - Legislative Count		3,000	3,000	0.000	0.000
Personal Services		237,637	242,439	0	0
All Other		1,154,007	8,645	0	0
TOTAL		1,391,644	251,084	0	0

Department/Program/Line Category	Account Number	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
TOTAL EXPENDITURES/ALLOCATIONS- All Departments and Agencies					
Positions - Legislative Count		23,500	19,500	9,000	9,000
Personal Services		1,943,794	1,710,585	1,017,395	1,057,866
All Other		60,451,170	54,570,413	49,338,621	49,368,621
TOTAL		62,394,964	56,280,998	50,356,016	50,426,487

Fund for a Healthy Maine Fact Sheet

Office: Child and Family Services

Date: 11-17-11

Program Title: Maine Families Home Visiting

Account: 014-095306, FHM-Home Visitation

I. Program Description:

1) Overview of the program:

Home Visiting was formally established in state statute (Title 22, §262) as an effective primary prevention public health strategy to meet the goals of the Department by improving the health and well-being of Maine's young children and their families through a connected network of home visiting providers.

In accordance with the federal definition of home visiting as outlined in the Social Security Act, Title V, Section 511(b)(U.S.C. 701), as amended by the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, home visiting is defined as an evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent, short-term or supplemental home visiting), and is offered on a voluntary basis to mothers, fathers, families, pregnant women, infants, and children.

Maine Families Home Visiting delivers cost-effective focused services to a vulnerable population at the most critical time of children's physical and emotional development.

2) Who is served with these funds (i.e. # of people, # of programs, etc):

The Maine Families Home Visiting Program serves vulnerable families of infants and toddlers. Typically, over 2500 families receive home visits each year. The families who received home visits were largely young (46% under age 23 at their child's birth), single or partnering (60%) and more likely to be facing economic challenges (over 1/3 of the families had incomes under \$10,000 for the year). The program is making special efforts to reach the highest risk babies such as those that are drug affected or exposed to family violence.

3) What is purchased with these funds:

Maine Families Home Visiting is an evidence-based program providing focused services in response to an individualized needs assessment and is offered in families' homes. Well-trained professionals work in partnership with parents to insure safe home environments, promote healthy growth and development for babies and young children, and provide key connections to state and local services as needs are identified.

Expectant parents receive support to have a healthy pregnancy and access prenatal care. Parents of newborns are supported in their adjustment to parenthood and information is provided related to critical areas such as prevention of shaken baby syndrome, SIDS, suffocation and unintended injuries. Beyond the newborn period, ongoing educational and support services are provided to the most vulnerable families at a level reflecting the families' needs.

4) What is the service delivery (i.e. state personnel, contracted services, etc):

Contracted home visiting program sites are located in various health, educational and community agency settings and are available in every county in Maine. Sites work closely with other community service providers to collaborate and avoid duplication of services.

5) Department Program Staff:

Number of employees: 0 Cost of employees: \$ 0

II. Relevant Legislative History:

- State funded community- based home visiting was piloted originally in 1994 and expanded across the state in 2000 with the availability of funding from the Tobacco Settlement Funds.
- 2007, Title 22, §262: Home visiting
- 2011, Ch. 77, LD 1504, *Resolve, to Ensure a Strong Start for Maine's Infants and Toddlers by Extending the Reach of High Quality Home Visitation*
- Social Security Act, Title V, Section 511 (42 U.S.C. §701) as amended by Section 2951 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	\$ 5,378,750	\$ 5,022,914	\$ 5,064,553	\$ 5,091,128	\$ 2,653,383	\$ 2,653,383
General Fund or Other Special Revenue					\$ 2,000,000	\$ 2,000,000
Federal Funds					\$ 4,000,000	\$ 5,200,000
Total	\$ 5,378,750	\$ 5,022,914	\$ 5,064,553	\$ 5,091,128	\$ 8,653,383	\$ 9,853,383

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program:

Fund for a Healthy Maine (FHM) funding represents 30.7% and 26.9% of the total funding for the Home Visitation program for FY 2012 and FY 2013 respectively.

IV. Program Eligibility Criteria:

Families may take part in the program beginning in pregnancy and may receive visits until their child turns three years of age. Beyond the prenatal/newborn period, eligibility for ongoing services is determined by an individualized needs assessment and is prioritized and focused on the most vulnerable families such as adolescents and those experiencing substance abuse, domestic violence, mental health issues, developmental/ health concerns or family stress.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☒ Yes ☐ No

If yes, please explain:

The Affordable Care Act – Maternal, Infant and Early Childhood Home Visiting Program grants (formula based grants and competitive expansion grant) were awarded to "effectively implement home visiting models (or a single home visiting model) in the state's at-risk community(ies) to promote improvements in the benchmark and participant outcome areas as specified in the legislation." States must use the federal funds to supplement, not supplant, funds from other sources for these early childhood home visiting services.

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:

- Healthy and strong parent-child attachment.
- Family health, emotional and physical well-being.
- Reduced incidence of child abuse and neglect.
- Positive and creative learning environment for the child.
- Family self-sufficiency.
- Positive and effective parenting.
- Parental competencies and self-confidence.
- Community linkages/reduced family isolation.
- Educational success.

2) Please describe how the outcomes are measured:

As a recipient of federal ACA funds, Maine is required to demonstrate improvements in 34 benchmarks covering several domains of health and well-being. The state home visiting plan submitted in June 2011 included detailed descriptions of how each benchmark is measured. One example is included below:

Benchmark I. Improved Maternal and Newborn Health	
Construct	(ii) Parental use of alcohol, tobacco, or illicit drugs
Indicator	Percentage of pregnant women enrolled in the program using tobacco at intake who have ceased tobacco use by 3 months post enrollment
Indicator Type	Outcome Measure
Measurable Objective <i>Operational definition of improvement</i>	Increase or maintain the percentage of enrolled pregnant women using tobacco who cease tobacco use within three months post-enrollment from year 1 baseline to the 3-year benchmark reporting period.
Measurement Tool	Behavioral Health Risk Screening Tool for Pregnant Women and Women of Childbearing Age (BHRST)
Validity of proposed measurement tool	The Virginia Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), Department of Health (VDH) and the Home Visiting Consortium developed the <i>Behavioral Health Risks Screening Tool for Pregnant Women and Women of Childbearing Age</i> based on the Integrated Screening Tool developed by the Institute for Health and Recovery (IHR). (IHR's tool may be located online at www.mhqp.org/guidelines/perinatalPDF/IHRIntegratedScreeningTool.pdf . Virginia follows Bright Futures Guidelines (www.brightfutures.org/mentalhealth) as a framework for prevention and use of standardized screening tools. This tool incorporates the 4P's Plus, EPDS-3 and a Domestic Violence screening question. The 4P's Plus tool reliably and effectively screens pregnant women screened for substance abuse, including those women typically missed by other perinatal screening methods. The overall reliability for the 5-item measure was 0.62. Seventy-four (32.5%) of the women had a positive screen. Sensitivity and specificity was very good at 87% and 76% respectively. Positive predictive validity was low (36%) but negative predictive validity was high (97%). According to the author, "In an evaluation of clinical experience with the 4P's Plus, effective identification of pregnant women at highest risk for substance use can be accomplished within the context of routine prenatal care." (Chasnoff, et al., 2005)

Benchmark I. Improved Maternal and Newborn Health	
Construct	(ii) Parental use of alcohol, tobacco, or illicit drugs
Population to be assessed	Caregiver (pregnant women)
Sampling Plan, if applicable	N/A All families included
Special Considerations	None
Data Collection Plan (Including schedule/how often)	All pregnant caregivers will be screened for alcohol, tobacco, and drug use using the BHRST. Baseline data results of the screen will be entered into the database, ongoing parent report on current use of tobacco will be collected at each visit and change will be captured in the online database.
Data Analysis Plan (include plan for the identification of scale scores, ratios, or other metrics most appropriate to the measurement proposed)	Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: <ul style="list-style-type: none"> • Enrollment from the start of the project period • Families identified as pregnant at enrollment • Tobacco use as noted from enrollment data • Tobacco use at date 3 months from enrollment The calculation will be determined by dividing the total number of pregnant women who cease tobacco use within three months post-enrollment by the number of women enrolled prenatally who are using tobacco (at any intensity) at enrollment.

3) Please describe the measurable outcomes of the program:

As a recipient of federal ACA funds, Maine is required to demonstrate improvements in 34 benchmarks covering the following domains: Improved maternal and newborn health; Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; Improvement in school readiness and achievement; Reduction in crime or domestic violence; improvements in family economic self-sufficiency; and, Improvements in the coordination and referrals for other community resources and supports. See Social Security Act, Title V, Section 511 (d) (1) (42 U.S.C. §701).

Highlights of the recent outcome data for Maine Families Home Visiting:

HEALTH AND DEVELOPMENT OUTCOMES (FY11)

- 99.8% of children have a primary care provider and 97.3% have health insurance.
- 93% are up to date with their well-child check-ups and their immunizations (20% higher than the Maine immunization rate).
- All age-eligible children are screened regularly for possible developmental delays (with parent permission). Seven percent of children on average are identified with possible delays and provided supports to help address those delays early before more costly remediation is needed in school.
- Of children exposed to second hand smoke, 39% are no longer exposed and 29% have reduced exposure, reducing their risk of developing respiratory and other related health issues.
- 94% of expectant mothers received adequate prenatal care (Maine rate 85%) resulting in fewer premature and low birth weight babies and saving significant related health care costs.

SAFETY OUTCOMES (FY10)

- 1% of children in the program were victims of substantiated abuse or neglect. (Maine rate 2.4%)
- Home Safety Assessment improved across all measures, with the largest impacts in fire prevention (23%), outdoor safety (38%) and car safety (27%).

PARENTS' REPORT OF POSITIVE CHANGE AS A RESULT OF PARTICIPATION:

- | | | | |
|---------------------|-----|---------------------|-----|
| • Child Development | 99% | • Car Seat Safety | 96% |
| • Home Safety | 98% | • Breastfeeding | 91% |
| • Child Nutrition | 98% | • Second-hand Smoke | 92% |
| • Child Discipline | 98% | | |

